

PRISON/MENTAL HEALTH FACILITY POPULATION VERIFICATION FORM

The purpose of this form is to verify the populations of D.O.C. facilities and state mental health institutions which entitle certain counties to additional state-paid deputy prosecuting attorneys. Please complete and return a signed original by 1/31 of each calendar year to: Division of State Court Administration, ATTN: Payroll Department, 115 West Washington Street, Suite 1080, Indianapolis, Indiana, 46204-3417.

County:

State-paid deputy prosecuting attorneys (please list by name; do not include chief deputies):

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

D.O.C institutions in county (please list name, address, and population)

- (1) _____ Population _____
- (2) _____ Population _____
- (3) _____ Population _____
- (4) _____ Population _____
- (5) _____ Population _____

Mental Health Facilities (as defined in IC 12-7-2-184)

- (1) _____ Population _____
- (2) _____ Population _____
- (3) _____ Population _____

I, _____, Prosecuting Attorney of _____ county, affirm that the information in this form is true and correct.

Printed Name

Signature

Date